

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES



# Medical Statement of Child in Childcare

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
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## Immunizations

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Yes  No

DPT / DT	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	Booster Date	Booster Date
Polio	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	Booster Date	Booster Date
Hib (conjugate preferred)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
MMR	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella / Chicken Pox	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			

## Other Immunizations

Type of Immunization:	Date:
Type of Immunization:	Date:

## Tests

Tuberculin Test Date: \_\_\_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm  
 TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_\_\_  
 Attach lead level statement

## Health Specifics

## Comments

Are there allergies? (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL INFORMATION ON REVERSE SIDE →

# Medical Statement of Child in Childcare (cont.)



## Summary of Physical Exam

Include special recommendations to Day Care Providers

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On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care.

Yes  No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( )

Phone

Date

## Religious Exemptions

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization. Do you wish to exercise those rights?

Yes  No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak. The child may return only upon approval of the local county health department.

Signature of Parent or Person Legally Responsible

Date